BlueCross BlueShield of Illinois

Applied Behavior Analysis

Initial Assessment Request

For questions, please call:
Blue Cross Community Health Plans℠: **877-860-2837**
Blue Cross Community MMAI (Medicare-Medicaid Plan)℠: **877-723-7702**
For BCBSIL BCCHP℠ please fax form to **888-530-9809**. For BCBSIL MMAI Fax Forms to **312-233-4099**.

PATIENT INFO

Patient Name _____ Patient Date of Birth _____ Request Submission Date _____

Subscriber Name _____ Subscriber ID _____ Group _____

Patient resides in what state? _____ Services conducted in same state? ☐ Yes ☐ No If no, what state? _____

DIAGNOSTIC PRACTITIONER INFO

Diagnostic Practitioner Name _____ NPI _____

Telephone _____ Fax _____ Contact Name _____

Diagnostic Practitioner Type, if PCP: ☐ Family Practice ☐ Internal Medicine ☐ Pediatrics

Diagnostic Practitioner Type, if Specialized ASD-Diagnosing Provider: ☐ Developmental Behavioral Pediatrics ☐ Neurodevelopmental Pediatrics

☐ Child Neurology ☐ Adult or Child Psychiatry ☐ Licensed Clinical Psychology ☐ Other (specify) _____

Primary Diagnosis Code _____ Secondary Diagnosis Code _____ Dates of Initial Evaluations _____ / _____ / _____

AUTHORIZATION/COMMUNICATION SENT TO

Facility Name _____ NPI _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ ext _____ Fax _____ Contact Name _____

BCBA Name _____ NPI _____ License/Cert _____

Address (if not same as above) _____ City _____ State _____ Zip Code _____

Telephone _____ ext _____ Fax _____ Contact Name _____

PROVIDER REQUEST

Assessment Request Start Date _____ / _____ / _____ to End Date _____ / _____ / _____

ABA Assessment Code Request (Total Units for Assessment Period; 1 Unit = 15 minutes)	97151 QHP	97152 Technician

Additional Code(s) Request and Reason

CERTIFICATION OF PROVIDER QUALIFICATIONS

ABA Supervisor Signature _____ Date _____ / _____ / _____

ABA Supervisor Printed Name _____ Clinic Name _____